STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD

Required when receiving payment from the State of California in lieu of IRS W-9)
204 (Rev. 6-2003)

1 **INSTRUCTIONS:** Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this **fully completed** form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.
NOTE: Governmental entities, federal, State, and local (including school districts), are not required to submit this form.

2

PAYEE'S LEGAL BUSINESS NAME (Type or Print): The Primary Source

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.):

E-MAIL ADDRESS: theprimarysource@msn.com

MAILING ADDRESS: 11367 Trade Center Dr, #110

BUSINESS ADDRESS: Same

CITY, STATE, ZIP CODE: Rancho Cordova, CA 95742

CITY, STATE, ZIP CODE: Same

3 **PAYEE ENTITY TYPE** **CHECK ONE BOX ONLY**

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 01-0801411 14

☐ PARTNERSHIP

☐ ESTATE OR TRUST

CORPORATION:
- ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ LEGAL (e.g., attorney services)
- ☐ EXEMPT (nonprofit)
- ☑ ALL OTHERS

☐ INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: ___-___-____

(SSN required by authority of California Revenue and Tax Code Section 18646)

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4 **PAYEE RESIDENCY STATUS**

☑ California resident - Qualified to do business in California or maintains a permanent place of business in California.

☐ California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.
- ☐ No services performed in California.
- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.

AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print): Bonnie Cerkleski

TITLE: President

SIGNATURE: Bonnie Cerkleski

DATE: 5-01-06

TELEPHONE: 916 858-2099

6 **Please return completed form to:**

Department/Office: Depart of General Services

Unit/Section: Procurement Division

Mailing Address: 707 3rd St.

City/State/Zip: West Sacramento, CA 95605

Telephone: 916 375-4478 Fax: 916 375-4613

E-mail Address: mallie.stone@dgs.ca.gov

ST CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)
STD. 204 (Rev. 6-2003)

1

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2

PAYEE'S LEGAL BUSINESS NAME (Type or Print): Cufis Technologies, Inc.

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.):

E-MAIL ADDRESS: eric@cufis.com

MAILING ADDRESS: 4231 Pacific Street, Suite 3

BUSINESS ADDRESS: 4231 Pacific Street, Suite 3

CITY, STATE, ZIP CODE: Rocklin, CA 95677

CITY, STATE, ZIP CODE: Rocklin, CA 95677

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 20-2124438

☐ PARTNERSHIP

☐ ESTATE OR TRUST

CORPORATION:
- ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ LEGAL (e.g., attorney services)
- ☐ EXEMPT (nonprofit)
- ☒ ALL OTHERS

☐ INDIVIDUAL OR SOLE PROPRIETOR
ENTER SOCIAL SECURITY NUMBER: ___-___-____
(SSN required by authority of California Revenue and Tax Code Section 18646)

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4

PAYEE RESIDENCY STATUS

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- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

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AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print): Eric Hoffman

TITLE: President

SIGNATURE:

DATE: 05/31/2006

TELEPHONE: (916) 652-4418

6

Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (___) _____ **Fax:** (___) _____

E-mail Address: _____

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)

STD. 204 (Rev. 6-2003)

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2

PAYEE'S LEGAL BUSINESS NAME (Type or Print): DATICA, INC dba The Very Last Word

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.):

E-MAIL ADDRESS:

MAILING ADDRESS: 50 E. HAMILTON AVE., Ste 280

CITY, STATE, ZIP CODE: CAMPBELL, CA 95008

BUSINESS ADDRESS: Same

CITY, STATE, ZIP CODE: Same

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 77-0428565

☐ PARTNERSHIP

☐ ESTATE OR TRUST

CORPORATION:

- ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ LEGAL (e.g., attorney services)
- ☐ EXEMPT (nonprofit)
- ☒ ALL OTHERS

☐ INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: ___-___-____

(SSN required by authority of California Revenue and Tax Code Section 18646)

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4

PAYEE RESIDENCY STATUS

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- ☐ No services performed in California.
- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

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AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print): ROBERT D. FARRELL

TITLE: President

SIGNATURE: [signature]

DATE: June 1, 2006

TELEPHONE: (408) 341-8809

6

Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (___) _____ Fax: (___) _____

E-mail Address: _____

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)
). 204 (Rev. 6-2003)

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2

PAYEE'S LEGAL BUSINESS NAME (Type or Print): MicroLeague Inc.

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.):

E-MAIL ADDRESS: jamess@microleague.com

MAILING ADDRESS: 12436 SANTA MONICA

BUSINESS ADDRESS: SAME

CITY, STATE, ZIP CODE: Los Angeles, CA 90025

CITY, STATE, ZIP CODE: SAME

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 95-4305358

☐ PARTNERSHIP

☐ ESTATE OR TRUST

CORPORATION:
- ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ LEGAL (e.g., attorney services)
- ☐ EXEMPT (nonprofit)
- ☑ ALL OTHERS

☐ INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: ___-___-____

(SSN required by authority of California Revenue and Tax Code Section 18646)

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4

PAYEE RESIDENCY STATUS

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- ☐ No services performed in California.
- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.

AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print): James E. Shipp

TITLE: Govt & Comm. Sales Mgr

SIGNATURE: James E Shipp

DATE: 6/1/06

TELEPHONE: (310) 450-2708

6

Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (___) _____ **Fax:** (___) _____

E-mail Address: _____

RFP DGS-55206
Section 8
EXHIBIT 8.7

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE
PAYEE DATA RECORD
(Required when receiving payment from the State of California in lieu of IRS W-9)
STD. 204 (Rev. 6-2003)

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2
PAYEE'S LEGAL BUSINESS NAME (Type or Print): Waldecks Inc
SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.):
E-MAIL ADDRESS: cliff@waldecks.com
MAILING ADDRESS: 500 Washington Street
BUSINESS ADDRESS: same
CITY, STATE, ZIP CODE: San Francisco CA 94111
CITY, STATE, ZIP CODE: same

3 **PAYEE ENTITY TYPE** **CHECK ONE BOX ONLY**
ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 94-1241718 60
☐ PARTNERSHIP
☐ ESTATE OR TRUST
CORPORATION:
☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)
☐ LEGAL (e.g., attorney services)
☐ EXEMPT (nonprofit)
☐ ALL OTHERS
☐ INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: ___-___-____
(SSN required by authority of California Revenue and Tax Code Section 18646)
NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4 **PAYEE RESIDENCY STATUS**
☒ California resident - Qualified to do business in California or maintains a permanent place of business in California.
☐ California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.
☐ No services performed in California.
☐ Copy of Franchise Tax Board waiver of State withholding attached.

5
I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.
AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print): Clifford Waldeck
TITLE: President
SIGNATURE: Clifford Waldeck
DATE: 5/02/06
TELEPHONE: (415) 981-3381

6
Please return completed form to:
Department/Office: _____
Unit/Section: _____
Mailing Address: _____
City/State/Zip: _____
Telephone: (___) _____ Fax: (___) _____
E-mail Address: _____

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)

STD. 204 (Rev. 6-2003)

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2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)
THE MARTINI GROUP, INC.

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)

E-MAIL ADDRESS
GLATONA@MARTINIGLOBAL.COM

MAILING ADDRESS
245 FISCHER AVE., BLD. C-2

CITY, STATE, ZIP CODE
COSTA MESA, CA 92626

BUSINESS ADDRESS
245 FISCHER AVE., BLD. C-2

CITY, STATE, ZIP CODE
COSTA MESA, CA 92626

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 90-0069056

☐ **PARTNERSHIP**

☐ **ESTATE OR TRUST**

CORPORATION:

- ☐ **MEDICAL** (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ **LEGAL** (e.g., attorney services)
- ☐ **EXEMPT** (nonprofit)
- ☑ **ALL OTHERS**

☐ **INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER:** ___-___-____

(SSN required by authority of California Revenue and Tax Code Section 18646)

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4

PAYEE RESIDENCY STATUS

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- ☐ No services performed in California.
- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

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AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)
GLEN LATONA

TITLE
PRESIDENT

SIGNATURE

DATE
09/27/2006

TELEPHONE
(714) 210-2501

6

Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (___) _____ **Fax:** (___) _____

E-mail Address: _____

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD

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2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)
DVBE Tech Inc.

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)
Eckert, Mark,

E-MAIL ADDRESS
mark@dvbetech.com

MAILING ADDRESS
5060 Sunrise Blvd. Suite A4

BUSINESS ADDRESS
Same

CITY, STATE, ZIP CODE
Fair Oaks, CA 95628

CITY, STATE, ZIP CODE
Same

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 68-0459531

☐ **PARTNERSHIP**

☐ **ESTATE OR TRUST**

CORPORATION:
- ☐ **MEDICAL** (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ **LEGAL** (e.g., attorney services)
- ☐ **EXEMPT** (nonprofit)
- ☑ **ALL OTHERS**

☐ **INDIVIDUAL OR SOLE PROPRIETOR**
ENTER SOCIAL SECURITY NUMBER: ___-___-____

(SSN required by authority of California Revenue and Tax Code Section 18646)

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4

PAYEE RESIDENCY STATUS

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- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

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AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)
Mark Eckert

TITLE
President

SIGNATURE
Mark Eck

DATE
May 5, 2006

TELEPHONE
(916) 960-0116 ext. 111

6

Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (___) _____ **Fax:** (___) _____

E-mail Address: _____

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

PAYEE DATA RECORD

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2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)
Hoffman Technologies, Inc.

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)

E-MAIL ADDRESS
gary@hoffmantech.com

MAILING ADDRESS
1800 Vernon Street, Suite 8

BUSINESS ADDRESS
Same

CITY, STATE, ZIP CODE
Roseville, CA 95678

CITY, STATE, ZIP CODE
Same

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 94-3278671

☐ PARTNERSHIP

☐ ESTATE OR TRUST

CORPORATION:
- ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ LEGAL (e.g., attorney services)
- ☐ EXEMPT (nonprofit)
- ☒ ALL OTHERS

☐ INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: ___-___-____
(SSN required by authority of California Revenue and Tax Code Section 18646)

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4

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- ☐ No services performed in California.
- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

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AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)
Gary C. Hoffman

TITLE
CEO/President

SIGNATURE
Gary C. Hoffman

DATE
May 1, 2006

TELEPHONE
916-782-5267

6

Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (___) _____ Fax: (___) _____

E-mail Address: _____

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

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2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)
SLM CONTRACT FURNITURE, INC.

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)

E-MAIL ADDRESS
tim@SLMCF.com

MAILING ADDRESS
7330-G Opportunity Rd

CITY, STATE, ZIP CODE
SAN DIEGO, CA 92111

BUSINESS ADDRESS
7330-G Opportunity Rd

CITY, STATE, ZIP CODE
SAN DIEGO, CA 92111

3 **PAYEE ENTITY TYPE**
CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 42-1582582

☐ **PARTNERSHIP**

☐ **ESTATE OR TRUST**

CORPORATION:
- ☐ **MEDICAL** (e.g., dentistry, psychotherapy, chiropractic, etc.)
- ☐ **LEGAL** (e.g., attorney services)
- ☐ **EXEMPT** (nonprofit)
- ☑ **ALL OTHERS**

☐ **INDIVIDUAL OR SOLE PROPRIETOR**
ENTER SOCIAL SECURITY NUMBER: ___-___-____
(SSN required by authority of California Revenue and Tax Code Section 18646)

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4 **PAYEE RESIDENCY STATUS**

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5

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AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)
Timothy MARONEY

TITLE
President

SIGNATURE
Timothy Maroney

DATE
5-2-06

TELEPHONE
858 277-9700

6

Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (___) _____ **Fax:** (___) _____

E-mail Address: _____

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

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2

PAYEE'S LEGAL BUSINESS NAME (Type or Print): OFFICE DEPOT, Inc.

SOLE PROPRIETOR – ENTER NAME AS SHOWN ON SSN (Last, First, M.I.):

E-MAIL ADDRESS: pat.welch@officedepot.com

MAILING ADDRESS	BUSINESS ADDRESS
6700 AutoMall Parkway	6700 AutoMall Parkway
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE
Fremont CA 94538	Fremont CA 94538

3 **PAYEE ENTITY TYPE** — **CHECK ONE BOX ONLY**

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 59-2663954

- ☐ PARTNERSHIP
- ☐ ESTATE OR TRUST
- CORPORATION:
  - ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.)
  - ☐ LEGAL (e.g., attorney services)
  - ☐ EXEMPT (nonprofit)
  - ☑ ALL OTHERS
- ☐ INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: ___-___-____

(SSN required by authority of California Revenue and Tax Code Section 18646)

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  - ☐ No services performed in California.
  - ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

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AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)	TITLE	
PAT WELCH	Vice President	
SIGNATURE	DATE	TELEPHONE
	5-3-06	(510) 497-5537

6 **Please return completed form to:**

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: (___) _____ Fax: (___) _____

E-mail Address: _____